BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
JOSEPH P. COTROPIA, M.D.	)	**Case No. 8002015012826**
Physician's and Surgeon's Certificate No. G43173	)	
Respondent	)	

DECISION

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on September 14, 2016

IT IS SO ORDERED September 7, 2016.

MEDICAL BOARD OF CALIFORNIA

By: _____
Kimberly Kirchmeyer
Executive Director

KAMALA D. HARRIS
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
KEITH C. SHAW
Deputy Attorney General
State Bar No. 227029
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5385
Facsimile: (415) 703-5480
E-mail: Keith.Shaw@doj.ca.gov
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JOSEPH P. COTROPIA, M.D.** 1756 Bison Meadow Lane Heath, TX 75032 Physician's and Surgeon's No. G 43173 Respondent.	Case No. 800-2015-012826 **STIPULATION SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties in this proceeding, that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical Board of California. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Keith C. Shaw, Deputy Attorney General.

2. On or about September 8, 1980, the Medical Board issued Physician's and Surgeon's Number G 43173 to Joseph P. Cotropia, M.D. (Respondent). Said certificate expires on July 31, 2016 and had been in retired status since September 25, 2014. On October 5, 2015, the Board issued an Out of State Suspension Order pursuant to California Business and Professions Code

section 2310, immediately suspending Respondent's license.

JURISDICTION

3. Accusation No. 800-2015-012826 was filed before the Medical Board of California ("Board"), Department of Consumer Affairs, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on December 10, 2015. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2015-012826 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

4. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2015-012826. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

5. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel, at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

6. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

7. Respondent agrees that based exclusively on the action taken by the Texas Medical Board as alleged in the Accusation, and not on any acts or conduct which occurred in California, cause exists to discipline his California physician's and surgeon's certificate pursuant to Business and Professions Code sections 141 and 2305. Respondent lives and practices in Texas and has no present plans to relocate to California; he wishes to surrender his California license at this time.

8. Pursuant to section 2224(b) of the Business and Professions Code, this Stipulation for Surrender of License shall be subject to the approval of the Board. Respondent understands and

agrees that the Medical Board's staff and counsel for Complainant may communicate directly with the Board regarding this Stipulation without notice to or participation by Respondent or his counsel. By signing this Stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the Stipulation prior to the time the Board considers and acts upon it. In the event that this Stipulation is rejected for any reason by the Board, it will be of no force or effect for either party. The Board will not be disqualified from further action in this matter by virtue of its consideration of this Stipulation.

9. Upon acceptance of this Stipulation by the Board, Respondent understands that he will no longer be permitted to practice as a physician and surgeon in California, and also agrees to surrender and cause to be delivered to the Board any license and wallet certificate in his possession before the effective date of the decision.

10. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

11. Respondent fully understands and agrees that if he ever files an application for relicensure or reinstatement in the State of California, the Board shall treat it as a petition for reinstatement, and Respondent must comply with all laws, regulations and procedures for reinstatement of a revoked license in effect at the time the petition is filed.

12. Respondent understands that he may not petition for reinstatement as a physician and surgeon for a period of three (3) years from the effective date of his surrender. Information gathered in connection with Accusation number 800-2015-012826 may be considered by the Board in determining whether or not the grant the petition for reinstatement. For the purposes of the reinstatement hearing, the allegations contained in Accusation number 800-2015-012826 shall be deemed to be admitted by Respondent, and Respondent waives any and all defenses based on a claim of laches or the statute of limitations.

13. The parties understand and agree that facsimile or electronic copies of this Stipulated Surrender of License, including facsimile or electronic signatures thereto, shall have the same force and effect as the originals.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my counsel. I enter into it freely and voluntarily and with full knowledge of its force and effect do hereby surrender my Physician and Surgeon's Certificate Number G 43173 to the Medical Board of California, for its formal acceptance. By signing this stipulation to surrender my license, I recognize that upon its formal acceptance by the Board, I will lose all rights and privileges to practice as a physician and surgeon in the State of California and I also will cause to be delivered to the Board any license and wallet certificate in my possession before the effective date of the decision.

DATED: 15 August 2016

JOSEPH P. COTROPIA, M.D.
Respondent

I concur with this stipulated surrender.

DATED: 8-15-16.

TOMMY E. SWATE, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated: 8/22/16

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General

KEITH C. SHAW
Deputy Attorney General
Attorneys for Complainant

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EXHIBIT A

KAMALA D. HARRIS
Attorney General of California
JANE ZACK SIMON
Supervising Deputy Attorney General
MACHAELA M. MINGARDI
Deputy Attorney General
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455 Golden Gate Avenue, Suite 11000
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Facsimile: (415) 703-5480
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **JOSEPH P. COTROPIA, M.D.** 1756 Bison Meadow Lane Heath, TX 75032 Physician's and Surgeon's No. G 43173, Respondent.	Case No. 800-2015-012826 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about September 8, 1980, the Medical Board issued Physician's and Surgeon's Number G 43173 to Joseph P. Cotropia, M.D. (Respondent). Said certificate expires on July 31, 2016 and had been in retired status since September 25, 2014. On October 5, 2015, the Board issued an Out of State Suspension Order pursuant to California Business and Professions Code section 2310, immediately suspending Respondent's license. A true and correct copy of the Out of State Suspension Order is attached herein as Exhibit A.

//

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following sections of the California Business and Professions Code ("Code") and/or other relevant statutory enactment:

A. Section 2227 of the Code provides in part that the Board may revoke, suspend for a period not to exceed one year, or place on probation, the license of any licensee who has been found guilty under the Medical Practice Act, and may recover the costs of probation monitoring.

B. Section 2305 of the Code provides, in part, that the revocation, suspension, or other discipline, restriction or limitation imposed by another state upon a license to practice medicine issued by that state, or the revocation, suspension, or restriction of the authority to practice medicine by any agency of the federal government, that would have been grounds for discipline in California under the Medical Practice Act, constitutes grounds for discipline for unprofessional conduct.

C. Section 141 of the Code provides:

> "(a) For any licensee holding a license issued by a board under the jurisdiction of a department, a disciplinary action taken by another state, by any agency of the federal government, or by another country for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action by the respective state licensing board. A certified copy of the record of the disciplinary action taken against the licensee by another state, an agency of the federal government, or by another country shall be conclusive evidence of the events related therein.
> (b) Nothing in this section shall preclude a board from applying a specific statutory provision in the licensing act administered by the board that provides for discipline based upon a disciplinary action taken against the licensee by another state, an agency of the federal government, or another country."

FIRST CAUSE FOR DISCIPLINE

(Discipline, Restriction, or Limitation Imposed by Another State)

4. On March 20, 2015, the Texas Medical Board issued a Final Order regarding Respondent's license to practice medicine in the State of Texas. The Final Order contains factual findings that Respondent delegated medical acts to nursing staff, including but not limited to prescribing controlled substances and dangerous drugs. The Final Order contains factual findings

that Respondent, through his nursing staff, failed to meet the standard of care with respect to nine patients who were being treated for chronic pain at an uncertified pain management clinic. These patients were found to have been given various controlled substances, often hydrocodone and Soma, without a proper examination, treatment plan, monitoring or medical justification. In addition, Respondent was found to have failed to properly supervise his Advanced Practice nurses and failed to maintain adequate medical records.

5. Respondent's license to practice medicine in the State of Texas was revoked. A true and correct copy of the Final Order issued by the Texas Medical Board is attached as Exhibit B.

6. Respondent's conduct and the action of the Texas Medical Board, as set forth in paragraphs 4 and 5 above, constitute cause for discipline pursuant to sections 2305 and/or 141 of the Code.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Number G 43173, issued to Joseph P. Cotropia, M.D.;

2. Revoking, suspending or denying approval of Joseph P. Cotropia, M.D.'s authority to supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Joseph P. Cotropia, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: December 3, 2015

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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EXHIBIT A

MEDICAL BOARD OF CALIFORNIA

Executive Office

October 5, 2015

Joseph Paul Cotropia, M.D.
1756 Bison Meadow Lane
Heath, TX 75032-5954

RE: NOTICE OF OUT OF STATE SUSPENSION ORDER
California License: G 43173
Case Number: 8002015012826

Dear Dr. Cotropia:

California Business and Professions Code section 2310 authorizes the Medical Board of California to immediately suspend the California medical license of any physician and surgeon whose medical license has been suspended or revoked in any other state or by any agency of the federal government. A copy of Business and Professions Code section 2310 is enclosed for your review.

The Medical Board of California has determined, upon review of certified documents from the Texas State Medical Board, that your Texas license to practice medicine was revoked on February 13, 2015. Based on this revocation, your California medical license has been suspended effective immediately. This action will be reported to the National Practitioner Data Bank and the Federation of State Medical Boards.

You have a right to a hearing on the issue of penalty, as provided by Business and Professions Code section 2310(c). This hearing will be held within 90 days from the date of request. You may send this request to:

Jose Guerrero
Supervising Deputy Attorney General
Department of Justice
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102

Should the status of your medical license in Texas change, please notify us immediately. If you have any questions regarding this matter, please contact Brenda Allen at (916) 263-2624.

Sincerely,

Kimberly Kirchmeyer
Executive Director

Enclosure

EXHIBIT B

Texas Medical Board

Mailing Address: P.O. Box 2018 • Austin, TX 78768-2018
Phone (512) 305-7010

PUBLIC PHYSICIAN VERIFICATION
AS OF 09/09/2015

NAME	COTROPIA, JOSEPH PAUL, MD
LIC #	F6543
ID NUM	65377
ISSUE DATE	08/24/1980
EXPIRATION DATE	05/31/2015
BIRTH DATE	1944
BIRTH PLACE	TEXAS
REGISTRATION STATUS	NOT ACTIVE
REGISTRATION STATUS DATE	03/20/2015
DISCIPLINARY STATUS	CANCELLED BY BOARD
DISCIPLINARY STATUS DATE	03/20/2015
LICENSE STATUS	
LICENSE STATUS DATE	
MEDICAL SCHOOL	UNIV OF TEXAS, SOUTHWESTERN MED SCH, DALLAS
GRADUATION YEAR	1973
LICENSURE METHOD	EXAMINATION
PRIMARY SPECIALTY	INTERNAL MEDICINE
SECONDARY SPECIALTY	IMMUNOLOGY
MAILING ADDRESS	779 NORMANDY STREET, STE 112 HOUSTON, TX 77015--3441
PRIMARY PRACTICE SITE	779 NORMANDY STREET, STE 112 HOUSTON, TX 77015--3441

DISCIPLINARY/LICENSURE RESTRICTIONS INFORMATION SHEET

TEXAS MEDICAL BOARD

09/09/2015

LICENSE NUMBER: F6543

COTROPIA, JOSEPH PAUL, MD

CURRENT INFORMATION (PHYSICIAN):

REGISTRATION DATE/STATUS: 03/20/2015 NOT ACTIVE

DISCIPLINARY DATE/STATUS: 03/20/2015 CANCELLED BY BOARD

LICENSURE DATE/STATUS:

ON APRIL 18, 2013, A FORMAL COMPLAINT WAS FILED BY THE BOARD. SOAH DOCKET 503-13-3809.MD

ON DECEMBER 13, 2013, A FIRST AMENDED COMPLAINT WAS FILED BYA THE BOARD.

ON FEBRUARY 13, 2015, THE BOARD ENTERED A FINAL ORDER REVOKING JOSEPH COTROPIA, M.D.'S TEXAS MEDICAL LICENSE. THE BOARD FOUND DR. COTROPIA, THROUGH ADVANCED PRACTICE NURSES HE SUPERVISED, FAILED TO MEET THE STANDARD OF CARE WITH RESPECT TO NINE PATIENTS THAT WERE TREATED FOR CHRONIC PAIN AT AN UNLICENSED PAIN MANAGEMENT CLINIC. ADDITIONALLY, DR. COTROPIA FAILED TO PROPERLY SUPERVISE HIS MIDLEVELS AND FAILED TO MAINTAIN ADEQUATE MEDICAL RECORDS. THE ACTION WAS BASED ON THE FINDINGS OF AN ADMINISTRATIVE LAW JUDGE AT THE STATE OFFICE OF ADMINISTRATIVE HEARINGS. THIS ORDER RESOLVES A FORMAL COMPLAINT FILED AT THE STATE OFFICE OF ADMINISTRATIVE HEARINGS. DR. COTROPIA HAS 20 DAYS FROM THE SERVICE OF THE ORDER TO FILE A MOTION FOR REHEARING.

ON MARCH 9, 2015, A MOTION FOR REHEARING WAS FILED BY DR. COTROPIA.

MARCH 20, 2015, MOTION FOR REHEARING WAS DENIED BY THE BOARD. ORDER DATED FEBRUARY 13, 2015 IS EFFECTIVE MARCH 20, 2015.

To review a copy of the Board Order(s), go to
http://www.tmb.state.tx.us/agency/professionalinfo.htm

and search the TMB Public Web Based Verification database for this individual. Once located, the record will provide a link to view the Board Order(s). Alternatively, you may submit a written request to the Texas Medical Board at the following address. For orders of 50 pages or more, a charge of .10 per page will be billed.

Following address. For orders of 50 pages or more, a charge of .10 per page will be billed

Texas Medical Board

Public Information Department, MC-251
P.O. Box 2018
Austin, TX 78768-2018
FAX: 512-463-9416

Board action information is updated on our computer system within 2 weeks following the board meeting at which the action was taken. To see the current board meeting schedule, please visit our web site at www.tmb.state.tx.us

Board action is not final until the appeals process is exhausted. The above-noted disciplinary status will indicate when the appeal process is complete.

STATE OF TEXAS
COUNTY OF TRAVIS

I, Cathy Lorentz, certify that I am an officer of the Texas Medical Board and that this is a true and correct copy of the original, as it appears on file in this office.

Witness my official hand and seal of the Board this 16th day of September, 2015

HEARING CONDUCTED BY THE
TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS
SOAH DOCKET NO. 503-13-3809.MD
TEXAS MEDICAL LICENSE NO. F-6543

IN THE MATTER OF THE	BEFORE THE
COMPLAINT AGAINST	
JOSEPH COTROPIA, M.D.	TEXAS MEDICAL BOARD

FINAL ORDER

During an open meeting at Austin, Texas, the Texas Medical Board (Board) finds that the above-styled case was assigned to Administrative Law Judge (ALJ) Sharon Cloninger of the State Office of Administrative Hearings (SOAH). A hearing was held on March 3-5, 2014, at the William P. Clements State Office Building, 300 West 15th Street, Fourth Floor, Austin, Texas. The record closed on September 22, 2014, and a Proposal for Decision (PFD) was served on both parties on November 20, 2014, and both parties were given an opportunity to file exceptions and replies as part of the record herein. Both parties filed exceptions and replies. After considering the exceptions and replies, on January 7, 2015, the ALJ amended proposed Finding of Fact No. 19.

The Board, after review and due consideration of the PFD, adopts the following Findings of Fact and Conclusions of Law.

I. FINDINGS OF FACT

Background

1. Joseph Paul Cotropia, M.D. (Respondent) holds Texas Medical License No. F-6543, originally issued to him by the Texas Medical Board (Board) on August 24, 1980.

2. Respondent's medical license was in full force and effect at all times relevant to this proceeding.

3. Respondent was the supervising physician for advanced practice nurses (APNs) at New Concept Medical Clinic (New Concept) and Best Choice Healthcare Management Group, LLC aka Best Choice Healthcare, PLLC, aka Best Choice Healthcare (Best Choice) located in Houston, Texas.

4. Respondent delegated medical acts to Iesha Grant, APN, at New Concept and was her supervising physician from March 15, 2011, to August 13, 2012.

5. Respondent delegated medical acts to Carol Reyes, APN, at Best Choice and was her supervising physician from September 1, 2011, to February 13, 2012; March 6-7, 2012; May 1 to October 1, 2012; and November 1, 2012, to December 13, 2013.

6. Respondent delegated medical acts to Carolyn Krenkel, APN, at Best Choice and was her supervising physician from October 31, 2011, to January 13, 2012.

7. Respondent delegated medical acts to Melissa Lockhart, APN, at Best Choice and was her supervising physician from September 1 to October 28, 2011.

8. During his supervision of Ms. Grant, Ms. Reyes, Ms. Krenkel, and Ms. Lockhart, Respondent delegated medical acts that included but were not limited to prescribing controlled substances and dangerous drugs.

9. Respondent, through the APNs, treated Patients 1 through 9, who are not named here due to the confidential nature of this matter but whose names were provided under seal to the Administrative Law Judge (ALJ) by Board Staff.

10. The APNs treated Patients 1 through 9 from March through December 2011.

11. Patients 1 through 7 were treated by Ms. Grant at New Concept and Patients 8 and 9 were treated by Ms. Lockhart, Ms. Krenkel, and Ms. Reyes at Best Choice.

12. The dates of treatment were from March to September 2011 (Patients 1 and 2); March to October 2011 (Patient 3); April to October 2011 (Patients 4, 5, 6, and 7); and September to December 2011 (Patients 8 and 9).

13. Patients 1 through 5 were treated for chronic back pain; Patient 6 for chronic back and shoulder pain; and Patients 7, 8, and 9 for chronic back and neck pain.

Protocols

14. The protocols in use at New Concept were inadequate for use in supervising Ms. Grant at the pain management clinic.

    a. Ms. Grant signed the protocols in March 2011, the same month she and Respondent entered into a collaborative agreement.

    b. The protocols are titled "Protocols & Guidelines."

c. The sentence directly above Ms Grant's signature states, "I have read and understand the Protocols for Pain Management Treatment."

15. Respondent had no current, written protocols in place for the APNs at Best Choice.

Pain Management Clinic Certificate

16. A majority of the patients at New Concept and Best Choice were, on a monthly basis, prescribed opioids, benzodiazepines, barbiturates, or carisoprodol.

17. New Concept and Best Choice were pain management clinics.

18. With some exceptions, pain management clinics must be registered with and obtain from the Board a pain management certificate.

19. New Concept was owned and operated by Ms. Grant.

20. Best Choice was owned and operated by an individual who was neither a physician nor an APN and the clinic was not exempt from certification.

21. Respondent was the medical director and sole physician at Best Choice during his delegation of medical acts to the APNs from September through January 2012.

22. Best Choice was not registered with the Board and did not have a pain management certificate from the Board when Respondent was associated with the clinic.

23. During the time Respondent served as the medical director at Best Choice, he allowed the facility to operate as a pain management clinic without the required pain management certificate.

Patient 1

24. Patient 1 visited New Concept six times between March and September 2011, and was treated by Ms. Grant, under Respondent's delegated authority, at each of those visits, for various conditions, including chronic back pain.

25. At five of the six visits, Patient 1 was prescribed the same dosage strength and quantity of Lortab and Soma without any explanation for the purpose of the medications documented in the medical records.

26. Lortab is a trade name for hydrocodone which is an opiate used to treat moderate to severe pain and is a Schedule III controlled substance.

27. Soma is the trade name for carisoprodol, a muscle relaxer and Schedule IV controlled substance.

28. The standard of care was not met because, at each visit, Ms. Grant did not appropriately evaluate the patient by taking histories that supported diagnoses or perform adequate physical examinations, and the treatment plans were inconsistent or incomplete.

29. Respondent, through Ms. Grant, failed to request Patient 1's prior medical records to evaluate Patient 1's prior treatments for pain, including past medications, to determine if they had any therapeutic benefit for Patient 1's pain.

30. Respondent, through Ms. Grant, failed to document a detailed history of Patient's 1's pain and treatment for pain, including the onset, location, severity, and ameliorating and aggravating factors of such pain.

31. Respondent, through Ms. Grant, performed an inadequate evaluation of Patient 1's pain complaints by failing to, among other things, perform adequate physical exams, order diagnostic imaging and/or tests, and consult with specialists.

32. Respondent, through Ms. Grant, failed to adequately develop and document a specific treatment plan for Patient 1, including goals for treatment.

33. Respondent, through Ms. Grant, failed to document and discuss with Patient 1 the risks and benefits of the proposed treatment.

34. Respondent, through Ms. Grant, failed to monitor Patient 1 for abuse or diversion with urine drug screens or by any other methods and failed to order liver function tests to monitor liver toxicity from the medications prescribed to Patient 1.

35. The standard of care was not met in monitoring Patient 1's use of narcotic pain medications over the course of the six visits to the clinic, covering about 6 months, in that no measures of compliance or risk assessment, such as urine drug screens, were used to ensure the patient was not abusing or diverting the narcotic pain medications.

36. Respondent, through Ms. Grant, did not document whether treatment modalities other than prescribing narcotic medications and administering massages were discussed with and recommended to Patient 1.

37. Respondent, through Ms. Grant, prescribed drugs and/or administered treatment to Patient 1 that were not adequately supported by objective medical evidence or documentation and were nontherapeutic.

Patient 2

38. Patient 2 visited New Concept six times from March to September 2011, and was treated by Ms. Grant, acting under Respondent's delegated authority, for various conditions including, but not limited to, chronic back pain.

39. At each visit, Ms. Grant prescribed the same dosage strength and quantity of Norco and Soma to Patient 2.

40. Norco is a trade name for hydrocodone, which is an opiate used to treat moderate to severe pain and is a Schedule III controlled substance.

41. Respondent, through Ms. Grant, failed to request Patient 2's prior medical records to evaluate the patient's prior treatments for pain, including past medications, to determine if they had any therapeutic benefit for the patient's pain.

42. Respondent, through Ms. Grant, failed to document a detailed history of Patient's 2's pain and treatment for pain, including the onset, location, severity, and ameliorating and aggravating factors of such pain.

43. Respondent, through Ms. Grant, performed an inadequate evaluation of Patient 2's pain complaints by failing to, among other things, perform adequate physical exams, order diagnostic imaging and/or tests, and consult with specialists.

44. Respondent, through Ms. Grant, failed to adequately develop and document a specific treatment plan for Patient 2, including goals for treatment.

45. Respondent, through Ms. Grant, failed to document and discuss with Patient 2 the risks and benefits of the proposed treatment and the reasonably foreseeable side effects of taking hydrocodone and carisoprodol.

46. Respondent, through Ms. Grant, failed to monitor Patient 2 for abuse or diversion of medications with urine drug screens or by any other methods and failed to order liver function tests to monitor liver toxicity from the prescribed medications.

47. The standard of care was not met in monitoring Patient 2's use of the narcotic pain medications over the course of the six visits to the clinic, covering about 6 months, in that no measures of compliance or risk assessment, such as urine drug screens, were used to ensure the patient was not abusing or diverting the narcotic pain medications.

48. Respondent, through Ms. Grant, did not document whether treatment modalities other than narcotic medications and massages were discussed with and recommended to Patient 2.

49. Respondent, through Ms. Grant, prescribed drugs and/or administered treatments that were not adequately supported by objective medical evidence or documentation and were nontherapeutic.

Patient 3

50. Between April and October 2011, Patient 3 visited New Concept seven times and was treated each time by Ms. Grant, who was acting under Respondent's delegated authority.

51. Ms. Grant treated Patient 3 for various conditions, including chronic back pain, and, at each visit, prescribed the same dosage strength and quantity of Lorcet and Soma for Patient 3.

52. Respondent, through Ms. Grant, failed to request Patient 3's prior medical records to evaluate the patient's prior treatments for pain, including past medications, to determine if they had any therapeutic benefit.

53. Respondent, through Ms. Grant, failed to document a detailed history of Patient 3's pain and treatment for pain, including the onset, location, severity, and ameliorating and aggravating factors of such pain.

54. Respondent, through Ms. Grant, inadequately evaluated Patient 3's pain complaints by failing to, among other things, perform proper physical exams, order diagnostic imaging and/or tests, and consult with specialists.

55. Respondent, through Ms. Grant, failed to adequately develop and document a specific treatment plan for Patient 3, including goals for treatment.

56. Respondent, through Ms. Grant, failed to document and discuss with Patient 3 the risks and benefits of proposed treatments.

57. Respondent, through Ms. Grant, failed to monitor Patient 3 for abuse or diversion with urine drug screens or by any other methods and failed to order liver function tests to monitor liver toxicity from the prescribed medications.

58. The standard of care was not met in monitoring Patient 3's use of the narcotic pain medications over the course of the seven visits to the clinic, covering about 6 months, in that no measures of compliance or risk assessment, such as urine drug screens, were used to ensure the patient was not abusing and/or diverting the narcotic pain medications.

59. Respondent, through Ms. Grant, failed to document whether treatment modalities other than narcotic medications and massages were discussed with and recommended to Patient 3.

60. Respondent, through Ms. Grant, prescribed drugs and/or treatment for Patient 3 that were nontherapeutic because, among other things, they were not adequately supported by objective medical evidence or documentation.

Patient 4

61. From April to October 2011, Respondent, through Ms. Grant, treated Patient 4 at New Concept for various conditions including, but not limited to, chronic back pain, and prescribed controlled substances and/or dangerous drugs to the patient.

62. Respondent, through Ms. Grant, failed to request Patient 4's prior medical records to evaluate the patient's prior treatments for pain, including past medications, to determine if they had any therapeutic benefit.

63. Respondent, through Ms. Grant, failed to document a detailed history of Patient 4's pain and treatment for pain, including the onset, location, severity, and ameliorating and aggravating factors of the pain.

64. Respondent, through Ms. Grant, performed an inadequate evaluation of Patient 4's pain complaints by failing to, among other things, perform adequate physical exams, order diagnostic imaging or tests, and consult with specialists.

65. Respondent, through Ms. Grant, failed to adequately develop and document a specific treatment plan for Patient 4, including short-term or long-term goals for treatment.

66. Respondent, through Ms. Grant, failed to document and discuss with Patient 4 the risks and benefits of the proposed treatment.

67. Respondent, through Ms. Grant, failed to monitor Patient 4 for abuse or diversion with urine drug screens or by any other methods and failed to order liver function tests to monitor Patient 4's liver toxicity from the prescribed medications.

68. The standard of care was not met in monitoring Patient 4's use of the narcotic pain medications over the course of the six visits to the clinic, covering about 6 months, in that no measures of compliance or risk assessment, such as urine drug screens, were used to ensure the patient was not abusing or diverting the narcotic pain medications.

69. Respondent, through Ms. Grant, failed to document whether treatment modalities other than narcotic medication prescriptions and massages were discussed with and recommended to Patient 4.

70. Respondent, through Ms. Grant, prescribed drugs or administered treatments for Patient 4 that were nontherapeutic because, among other things, they were not adequately supported by objective medical evidence or documentation.

Patient 5

71. From April to October 2011, Respondent, through Ms. Grant, treated Patient 5 at New Concept for various conditions including, but not limited to, chronic back pain, and prescribed controlled substances and/or dangerous drugs to Patient 5 in the course of the treatment.

72. Respondent, through Ms. Grant, failed to request Patient 5's prior medical records to evaluate prior treatments for pain, including past medications, to determine if they had any therapeutic benefit.

73. Respondent, through Ms. Grant, failed to document a detailed history of Patient 5's pain and treatment for pain, including the onset, location, severity, and ameliorating and aggravating factors of the pain.

74. Respondent, through Ms. Grant, performed an inadequate evaluation of Patient 5's pain complaints by failing to, among other things, perform adequate physical exams, order diagnostic imaging or tests, and consult with specialists.

75. Respondent, through Ms. Grant, failed to adequately develop and document a specific treatment plan for Patient 5, including short-term or long-term goals for treatment.

76. Respondent, through Ms. Grant, failed to document and discuss with Patient 5 the risks and benefits of proposed treatments.

77. Respondent, through Ms. Grant, failed to monitor Patient 5 for abuse or diversion with urine drug screens or by any other methods and failed to order liver function tests to monitor liver toxicity from the medications prescribed to Patient 5.

78. The standard of care was not met in monitoring Patient 5's use of the narcotic pain medications over the course of the seven visits to the clinic, covering about 6 months, in that no measures of compliance or risk assessment, such as urine drug screens, were used to ensure the patient was not abusing or diverting the narcotic pain medications.

79. Respondent, through Ms. Grant, did not document whether modalities other than narcotic medications and massages were discussed with and recommended to Patient 5.

80. Respondent, through Ms. Grant, prescribed drugs or treatment for Patient 5 that were nontherapeutic because, among other things, they were not adequately supported by objective medical evidence or documentation.

Patient 6

81. From April to October 2011, Respondent, through Ms. Grant, treated Patient 6 at New Concept for various conditions including, but not limited to, chronic back pain and shoulder pain, and prescribed controlled substances and/or dangerous drugs to Patient 6 in the course of treatment.

82. Respondent, through Ms. Grant, failed to request Patient 6's prior medical records to evaluate Patient 6's prior treatments for pain, including past medications, to determine if they had any therapeutic benefit.

83. Respondent, through Ms. Grant, failed to document a detailed history of Patient 6's pain and treatment for pain, including the onset, location, severity, and ameliorating and aggravating factors of such pain.

84. Respondent, through Ms. Grant, inadequately evaluated Patient 6's pain complaints by failing to, among other things, perform adequate physical exams, order diagnostic imaging or tests, and consult with specialists.

85. Respondent, through Ms. Grant, failed to adequately develop and document a specific treatment plan for Patient 6, including short-term or long-term goals for treatment.

86. Respondent, through Ms. Grant, failed to document and discuss with Patient 6 the risks and benefits of proposed treatments.

87. Respondent, through Ms. Grant, failed to monitor Patient 6 for abuse or diversion with urine drug screens or by any other methods and failed to order liver function tests to monitor liver toxicity from the prescribed medications.

88. The standard of care was not met in monitoring Patient 6's use of the narcotic pain medications over the course of the six visits to the clinic, covering about 6 months, in that no measures of compliance or risk assessment, such as urine drug screens, were used to ensure the patient was not abusing or diverting the narcotic pain medications.

89. Respondent, through Ms. Grant, did not document whether modalities other than narcotic medications and massages were discussed with and recommended to Patient 6.

90. Respondent, through Ms. Grant, prescribed drugs or treatment for Patient 6 that were nontherapeutic because, among other things, they were not adequately supported by objective medical evidence or documentation.

Patient 7

91. From April to October 2011, Respondent, through Ms. Grant, treated Patient 7 at New Concept for various conditions including, but not limited to, chronic back pain and neck pain, and prescribed controlled substances or dangerous drugs to Patient 7 in the course of such treatment.

92. Respondent, through Ms. Grant, failed to request Patient 7's prior medical records to evaluate Patient 7's prior treatments for pain, including past medications, to determine if they had any therapeutic benefit.

93. Respondent, through Ms. Grant, failed to document a detailed history of Patient 7's pain and treatment for pain, including the onset, location, severity, and ameliorating and aggravating factors of such pain.

94. Respondent, through Ms. Grant, inadequately evaluated Patient 7's pain complaints by failing to, among other things, perform adequate physical exams, order diagnostic imaging or tests, and consult with specialists.

95. Respondent, through Ms. Grant, failed to adequately develop and document a specific treatment plan for Patient 7, including short-term or long-term goals for treatment.

96. Respondent, through Ms. Grant, failed to document and discuss with Patient 7 the risks and benefits of proposed treatments.

97. Respondent, through Ms. Grant, failed to monitor Patient 7 for abuse or diversion with urine drug screens or by any other methods and failed to order liver function tests to monitor liver toxicity from the prescribed medications.

98. The standard of care was not met in monitoring Patient 7's use of the narcotic pain medications over the course of the six visits to the clinic, spanning about 6 months, in that no measures of compliance or risk assessment, such as urine drug screens, were used to ensure the patient was not abusing or diverting the narcotic pain medications.

99. Respondent, through Ms. Grant, failed to document whether modalities other than narcotic medications and massages were discussed with and recommended to Patient 7.

100. Respondent, through Ms. Grant, prescribed drugs or treatments for Patient 7 that were nontherapeutic because, among other things, they were not adequately supported by objective medical evidence or documentation.

Patient 8

101. From September to December 2011, Respondent, through the APNs, treated Patient 8 at Best Choice for various conditions including, but not limited to, chronic back and neck pain, and prescribed controlled substances or dangerous drugs in the course of Patient 8's treatment.

102. Respondent, through the APNs, failed to request Patient 8's prior medical records to evaluate prior treatments for pain, including past medications, to determine if they had any therapeutic benefit.

103. Respondent, through the APNs, failed to present to, discuss with, and obtain a signed written medication management agreement for chronic pain opioid therapy.

104. Respondent, through the APNs, failed to document a detailed history of Patient 8's pain and treatment for pain, including the onset, location, severity, and ameliorating and aggravating factors of the pain.

105. Respondent, through the APNs, inadequately evaluated Patient 8's pain complaints by failing to, among other things, perform adequate physical exams, order diagnostic imaging or tests, and consult with specialists.

106. Respondent, through the APNs, failed to adequately develop and document a specific treatment plan for Patient 8, including short-term or long-term goals for treatment.

107. Respondent, through the APNs, failed to document and discuss with Patient 8 the risks and benefits of proposed treatments.

108. Respondent, through the APNs, prescribed Soma, a controlled substance, without documenting a diagnosis or any other medical basis to support prescribing Soma to Patient 8.

109. Respondent, through the APNs, failed to monitor Patient 8 for abuse or diversion with urine drug screens or by any other methods.

110. The standard of care was not met in monitoring Patient 8's use of the narcotic pain medications over the course of the four visits to the clinic, covering about 4 months, in that no measures of compliance or risk assessment, such as urine drug screens, were used to ensure the patient was not abusing or diverting the narcotic pain medications.

111. Respondent, through the APNs, failed to document whether modalities other than narcotic medications and massages were discussed with and recommended to Patient 8.

112. Respondent, through the APNs, prescribed drugs or treatments for Patient 8 that were nontherapeutic because, among other things, they were not adequately supported by objective medical evidence or documentation.

Patient 9

113. From September to December 2011, Respondent, through the APNs, treated Patient 9 at Best Choice for various conditions including, but not limited to, chronic back and neck pain, and prescribed controlled substances or dangerous drugs to Patient 9 in the course of treatment.

114. Respondent, through the APNs, failed to request Patient 9's prior medical records to evaluate prior treatments for pain, including past medications, to determine if they had any therapeutic benefit.

115. Respondent, through the APNs, failed to document a detailed history of Patient 9's pain and treatment for pain, including the onset, location, severity, and ameliorating and aggravating factors of the pain.

116. Respondent, through the APNs, inadequately evaluated Patient 9's pain complaints by failing to, among other things, perform adequate physical exams, order diagnostic imaging or tests, and consult with specialists.

117. Respondent, through the APNs, failed to adequately develop and document a specific treatment plan for Patient 9, including short-term or long-term goals.

118. Respondent, through the APNs, failed to document and discuss with Patient 9 the risks and benefits of proposed treatments.

119. Respondent, through the APNs, failed to monitor Patient 9 for abuse or diversion with urine drug screens or by any other methods.

120. The standard of care was not met in monitoring Patient 9's use of the narcotic pain medications over the course of the four visits to the clinic, covering about 4 months, in that no measures of compliance or risk assessment, such as urine drug screens, were used to ensure the patient was not abusing or diverting the narcotic pain medications.

121. Respondent, through the APNs, prescribed Soma, a controlled substance, without documenting a diagnosis or any other medical basis to support prescribing Soma to Patient 9.

122. Respondent, through the APNs, failed to document whether modalities other than narcotic medications and massages were discussed with and recommended to Patient 9.

123. Respondent, through the APNs, prescribed drugs or treatments for Patient 9 that were nontherapeutic because, among other things, they were not adequately supported by objective medical evidence or documentation.

Procedural History

124. On April 18, 2013, Board Staff referred this contested case to the State Office of Administrative Hearings (SOAH) and filed its Complaint against Respondent.

125. Pursuant to the parties' request, the ALJ referred the case to mediation on July 30, 2013.

126. On November 8, 2013, the mediators filed a report stating the parties were unable to settle the matter and returned the case to the ALJ.

127. Staff filed its Notice of Hearing and First Amended Complaint on December 13, 2013. The Notice of Hearing and First Amended Complaint contained a statement of the legal authority and jurisdiction under which the hearing was to be held; a reference to the applicable rules and statutes, and short plain statement of the matters asserted.

128. The hearing on the merits convened on March 3, 2014, and continued through March 5, 2014. Staff Attorney-in-Charge Patrick Brian Coats and Staff Attorney Nycia Deal represented Staff. Attorney Tommy E. Swate represented Respondent. The record closed on September 22, 2014, after the parties submitted written closing arguments.

II. CONCLUSIONS OF LAW

1. The Board has jurisdiction over this matter pursuant to the Medical Practices Act (Act), Texas Occupations Code, Title 3, Subchapter B, chapters 151-165.

2. SOAH has jurisdiction to hold a contested case hearing and to issue findings of fact and conclusions of law, subject to the provisions of Section 164.007 of the Act, pursuant to Texas Government Code ch. 2003.

3. Notice of the complaint and of the hearing on the merits was provided as required by Section 164.005(f) of the Act and Texas Government Code §§ 2001.051 and 2001.052.

4. Staff had the burden to prove the alleged violations by a preponderance of the evidence. 1 Tex. Admin. Code § 155.427.

5. Respondent, through the APNs, did not treat Patients 1 through 9 according to the generally accepted standard of care for the treatment of chronic pain. 22 Tex. Admin. Code § 190.8(1)(A).

6. Respondent did not use proper diligence in his professional practice. 22 Tex. Admin. Code § 190.8(1)(C).

7. Respondent did not safeguard against potential complications. 22 Tex. Admin. Code § 190.8(1)(D).

8. Respondent failed to disclose reasonably foreseeable side effects of a procedure or treatment. 22 Tex. Admin. Code § 190.8(1)(G).

9. Respondent failed to disclose reasonable alternative treatments to proposed treatments. 22 Tex. Admin. Code § 190.8(1)(H).

10. Because Respondent failed to practice medicine in an acceptable professional manner consistent with public health and welfare as defined at 22 Texas Administrative Code § 190.8(1)(A), (C), (D), (G), and (H), the Board is authorized to discipline him pursuant to Section 164.051(a)(3) and (a)(6) of the Act.

11. Respondent did not maintain adequate medical records. 22 Tex. Admin. Code § 165.1(a).

12. Respondent did not adhere to established guidelines and requirements for the treatment of pain. 22 Tex. Admin. Code § 170.3.

13. Respondent did not obtain informed consent from Patient 2. 22 Tex. Admin. Code § 170.3(3).

14. Respondent was responsible for the acts he delegated to the APNs and did not adequately supervise them to ensure that the treatment of Patients 1 through 9 met the standard of care. Section 157.001(b) of the Act.

15. Having inadequate protocols in place at New Concept and having outdated protocols in place at Best Choice did not violate any Board rule and Respondent is not subject to disciplinary action under Section 164.051(a)(3) of the Act for violation of a Board rule related to having current protocols in place.

16. The Board is authorized to take disciplinary action against Respondent pursuant to Section 164.051(a)(3) of the Act due to his violation of 22 Tex. Admin. Code §§ 165.1(a), 170.3, and 190.8(1)(A), (D), (G).

17. Best Choice was required to be registered with and certified by the Board as a pain management clinic. Section 168.101(a) of the Act.

18. The Board is authorized to take disciplinary action against Respondent for violation of Section 168.101(a) of the Act, which requires pain management clinics to be certified, and for violating Texas Health and Safety Code § 481.129(c), related to prescribing controlled substances without a valid medical purpose. Sections 164.051(a)(1), 164.052(a)(5), 164.053(a)(1) of the Act.

19. The Board is authorized to take disciplinary action against Respondent for committing a prohibited act or practice connected with the physician's practice of medicine by prescribing a drug or treatment that is nontherapeutic in nature or nontherapeutic in the manner the drug or treatment is prescribed. Section 164.053(a)(5).

20. The Board is authorized to take disciplinary action against Respondent for committing a prohibited act or practice by prescribing dangerous drugs as defined by Health and Safety Code ch. 481 and controlled substances scheduled in Health and Safety Code ch. 481 or the Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. § 801 *et seq.)* in a manner inconsistent with public health and welfare. Section 164.053(a)(6).

21. The Board is authorized to take disciplinary action against Respondent due to his failure to adequately supervise Ms. Grant in her treatment of Patient 3. Section 164.053(a)(8).

22. The Board has the sole and exclusive authority to impose sanctions for violation of the Medical Practice Act or a Board rule and to issue a Final Order. Section 164.007(a) of the Act; 22 Tex. Admin. Code § 187.37(d)(2).

23. The Board may consider aggravating and mitigating factors in reaching a determination of sanctions. 22 Tex. Admin. Code § 190.15.

24. One or more of Respondent's violations involved more than one patient. 22 Tex. Admin. Code § 190.15.

25. Respondent's violations resulted in increased potential harm to the public. 22 Tex. Admin. Code § 190.15.

III ORDER

The Board hereby adopts the findings of fact and conclusions of law as proposed by the ALJ and ORDERS that:

1. Respondent's Texas medical license is hereby REVOKED.

2. Respondent shall immediately cease practice in Texas. Respondent's practice in the state of Texas after the date of entry of this Final Order shall constitute a violation of this Order, subjecting Respondent to disciplinary action by the Board or prosecution for practicing without a license in Texas.

3. Respondent shall comply with all the provisions of the Medical Practice Act and other statutes regulating the Respondent's practice.

4. Respondent may petition the Board for reissuance of his Texas medical license after one year's time from the effective date of this Final Order. Respondent may apply for reissuance of his Texas medical license pursuant to applicable Board Rules and Statutes, including but not limited to Sections 164.151 and 164.152, and Board Rules 163 and 167. The Board may inquire into the request for reissuance and, may in its sole discretion, grant or deny the petition without further appeal to or review by the Board. Petitions for reissuance may be filed only once a year thereafter. Respondent does not waive and specifically reserves his right to appeal any final decision of the Board regarding re-licensure to the State Office of Administrative Hearings.

SIGNED AND ENTERED by the presiding officer of the Texas Medical Board on this 13 day of February, 2015.

Michael Arambula, M.D., Pharm.D., President
Texas Medical Board